STATE OF SD WORKERS' COMPENSATION PROGRAM
DIRECT DEPOSIT AUTHORIZATION FORM

Completion of this form authorizes your disability benefit payment to be deposited directly into a checking or savings account. All disability benefits to which you are entitled will be deposited into your account. Proof of your deposit will appear on your bank statement.

Employee/Participant Name: _____ **SSN:** _____/_____/_____
Last First MI

I hereby authorize the State of SD Workers' Compensation Program to initiate credit entries into the depository which I have indicated below, and to initiate any debit or credit entries to my account that may be needed to correct any errors that have occurred:

☐ Checking Account ☐ Savings Account

NOTE: Before the ACH option takes effect, a pre-notification transaction is sent to the bank for verification of bank and account information. The next disbursement after this election will be a negotiable check**.** The remaining payments will be via ACH. Any ACH transaction stopped by the bank will cancel your ACH election until corrections can be made.

****A VOIDED CHECK MUST BE ATTACHED****

TAPE VOIDED CHECK HERE

THIS FORM WILL NOT BE PROCESSED WITHOUT A VOIDED CHECK

Account Number: _____

Depository (Financial Institution): _____

Address of Depository: _____
Street City State Zip

Bank ACH Transit Routing Number: _____

I give authorization to the financial institution listed above to release my address and telephone number to a duly authorized representative from the State of SD Workers' Compensation Program.

I agree to advise the State of SD Workers' Compensation Program of any changes in my address and telephone number. In the event the State of SD Workers' Compensation Program is not advised of a change in my address and telephone number, payment of disability benefit payments may be delayed.

This authority will remain in full force and effect until the State of SD Workers' Compensation Program has received written notification from me of its termination in such time and in such manner as to afford the State of SD Workers' Compensation Program a reasonable opportunity to act on it or a determination is made from the State of SD Workers' Compensation Program that I am no longer eligible to receive disability benefit payments.

The State of SD Workers' Compensation Program is not responsible for any bank fees related to expenditures made before an actual ACH deposit is in your account. It is your responsibility to verify that the funds are in your account before you expend them.

Signature: _____ **Date:** _____